

# STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: A.M.A. Care Home LLC	CHAPTER 100.1
Address: 94-392 Kahuanani Street, Waipahu, Hawaii 96797	Inspection Date: September 11, 2020 Initial

THIS PAGE MUST BE SUBMITTED WITH YOUR PLAN OF CORRECTION. IF IT IS NOT, YOUR PLAN OF CORRECTION WILL BE RETURNED TO YOU, UNREVIEWED.

YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) WORKING DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-3 <u>Licensing</u> , (a)(4) No person, group of persons, or entity shall operate an ARCH or expanded ARCH without a license previously obtained under and in compliance with this chapter and chapter 321, HRS.  The license issued by the department shall be posted in a conspicuous place visible to the public, on the premises of the ARCH or expanded ARCH;  <u><b>FINDINGS</b></u> License issued by the department was not posted.  Primary care giver (PCG) posted the license during the inspection.	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p>	<p style="text-align: center;">9/11/20</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-3 Licensing. (a)(4) No person, group of persons, or entity shall operate an ARCH or expanded ARCH without a license previously obtained under and in compliance with this chapter and chapter 321, HRS.  The license issued by the department shall be posted in a conspicuous place visible to the public, on the premises of the ARCH or expanded ARCH;  <b>FINDINGS</b> License issued by the department was not posted.  Primary care giver (PCG) posted the license during the inspection.	<p style="text-align: center;">PART 2 <u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>When receiving envelope containing license from the department, PCG/SCG to open + post license in conspicuous place, promptly.</i></p>	<p style="text-align: right;">3/24/21</p>

DIVISION OF LICENSING  
 ARCH-HQ  
 HAWAII STATE

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 Personnel, staffing and family requirements. (a) All individuals who either reside or provide care or services to residents in the Type I ARCH, shall have documented evidence that they have been examined by a physician prior to their first contact with the residents of the Type I ARCH, and thereafter shall be examined by a physician annually, to certify that they are free of infectious diseases.</p> <p><b>FINDINGS</b> Substitute care giver (SCG) #3 - No physical examination. Submit a copy with the plan of correction (POC).</p>	<p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b> YES</p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>As of 9/16/20, SCG #3 is no longer employed @ AMM Care Home LLC</p> <p>Arlyn Guey is now the live-in caregiver.</p>	<p>9/16/20</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-9 Personnel, staffing and family requirements. (a) All individuals who either reside or provide care or services to residents in the Type I ARCH, shall have documented evidence that they have been examined by a physician prior to their first contact with the residents of the Type I ARCH, and thereafter shall be examined by a physician annually, to certify that they are free of infectious diseases.  <u>FINDINGS</u> Substitute care giver (SCG) #3 - No physical examination. Submit a copy with the plan of correction (POC).	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>PCs to develop spreadsheet to keep track of PE clearances that contains expiration date. PCs to remind SCG's one month prior to expiration of PE clearance &amp; to make sure that SCG's have the day off to get the PE completed. PCs to followup &amp; make to obtain a copy of document (PE clearance).</p>	<p style="text-align: right;">3/24/21</p>

DIVISION OF STATE  
DOH-ONCA  
STATE OF HAWAII

APR 30 12:30

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 Personnel, staffing and family requirements. (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance.</p> <p><b>FINDINGS</b> SCG #1 - No tuberculosis (TB) clearance. <b>Submit a copy with the POC.</b></p> <p>SCG #2 - No documentation of positive TB skin test. <b>Submit a copy with the POC.</b></p> <p>SCG #3 - No documentation of positive TB skin test. <b>Submit a copy with the POC.</b></p>	<p style="text-align: center;"><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b> Yes</p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>PCG gathered all necessary documents from <del>SCG</del> SCG and filed it in ARCH binder (Pls see attached documents)</p> <p>* SCG #3 is no longer employed with A.M.A. Care Home LLC</p>	<p style="text-align: right;">12/28/22</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-9 Personnel, staffing and family requirements. (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance. <u>FINDINGS</u> SCG #1 - No tuberculosis (TB) clearance. Submit a copy with the POC. SCG #2 - No documentation of positive TB skin test. Submit a copy with the POC. SCG #3 - No documentation of positive TB skin test. Submit a copy with the plan of correction (POC).	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>Prior to initial Resident contact, PCG will ask SCG if they have had 2 steps TB clearance and obtain a copy. If SCG has been tested positive, ask for proof of positive test, chest x-ray, and TB screening clearance from MD.</i></p>	<p style="text-align: right;"><i>3/24/21</i></p>

LICENSING  
 ARCH-ORCA  
 STATE OF HAWAII

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§ 11-100.1-9 Personnel, staffing and family requirements, (e)(3)            The substitute care giver who provides coverage for a period less than four hours shall:             Be currently certified in first aid;   <b>FINDINGS</b>            SCG #1 - No first aid certification. Submit a copy with the POC.</p>	<p><b>PART 1</b>  <u>DID YOU CORRECT THE DEFICIENCY?</u> <i>YFS</i>             USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY   <i>PGs obtained a copy from SCs and filed in the ARCH's binder.</i></p>	<p><i>12/28/20</i></p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-9 Personnel, staffing and family requirements. (e)(3) The substitute care giver who provides coverage for a period less than four hours shall:  Be currently certified in first aid;  <u>FINDINGS</u> SCG #1 - No first aid certification. Submit a copy with the POC.	<p style="text-align: center;">PART 2 <u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>Prior to initial resident contact, PEG to ensure that SCG has <del>that</del> TA certification, and obtain a copy for ARCH file. -PEG to use employee checklist, and to be check monthly; remind SCG one month prior to expiration.</i></p>	<p style="text-align: right;"><i>3/24/24</i></p>

DIVISION OF  
COMMUNITY CARE  
STATE OF HAWAII

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RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-9 Personnel, staffing and family requirements. (e)(4) The substitute care giver who provides coverage for a period less than four hours shall:  Be trained by the primary care giver to make prescribed medications available to residents and properly record such action.  <b>FINDINGS</b> SCG #1, #2, #3 - No training by the PCG to make prescribed medication available to the resident. <b>Submit a copy for each with the POC.</b>	<p style="text-align: center;"><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b> <i>Yes</i></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p><i>PCG performed necessary training to SCG's re: medication administration and recording of such actions.</i></p>	<p style="text-align: right;"><i>12/28/20</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 Personnel, staffing and family requirements. (e)(4) The substitute care giver who provides coverage for a period less than four hours shall:</p> <p>Be trained by the primary care giver to make prescribed medications available to residents and properly record such action.</p> <p><u>FINDINGS</u> SCG #1, #2, #3 - No training by the POC to make prescribed medication available to the resident. <b>Submit a copy for each with the POC.</b></p>	<p><b>PART 1</b></p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>PCG provided proper training to SCG. - Copy submitted</i></p>	<p><i>YES</i></p>
	<p>03:29 30 APR 12.</p> <p>STATE OF HAWAII DEPARTMENT OF HEALTH LICENSING DIVISION</p>		

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-9 <u>Personnel, staffing and family requirements.</u> (c)(4) The substitute care giver who provides coverage for a period less than four hours shall:  Be trained by the primary care giver to make prescribed medications available to residents and properly record such action.  <b>FINDINGS</b> SCG #1, #2, #3 - No training by the PCG to make prescribed medication available to the resident. <b>Submit a copy for each with the POC.</b>	<p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><u><b>FUTURE PLAN</b></u></p> <p><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>PCG to ensure that all new SCG's are properly trained to handle resident's medication. Annual training by PCG to SCG's to follow.</p> <p>PCG to use employee checklist, to make sure SCG is trained, prior to contact w/ resident.</p>	<p style="text-align: right;">3/24/21</p>

STATE LICENSING  
DIVISION  
STATE OF HAWAII

03:27 PM 03/24/21

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-9 Personnel, staffing and family requirements. (f)(1) The substitute care giver who provides coverage for a period greater than four hours in addition to the requirements specified in subsection (e) shall:  Be currently certified in cardiopulmonary resuscitation;  <b>FINDINGS</b> SCG #1 - No cardiopulmonary resuscitation certification. <b>Submit a copy with the POC.</b>	<p style="text-align: center;"><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b>    <i>YES</i></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p><i>PCG obtained a copy from SCG and filed it in the ARCH's binder</i></p>	<p style="text-align: right;"><i>12/28/20</i></p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-9 Personnel, staffing and family requirements, (f)(1) The substitute care giver who provides coverage for a period greater than four hours in addition to the requirements specified in subsection (e) shall:  Be currently certified in cardiopulmonary resuscitation;  <u><b>FINDINGS</b></u> SCG #1 - No cardiopulmonary resuscitation certification. <b>Submit a copy with the POC.</b>	<p style="text-align: center;"><b>PART 1</b></p> <p><u><b>DID YOU CORRECT THE DEFICIENCY?</b></u></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p style="text-align: center;"><i>PCs obtained a copy from SCG. Copy Submitted</i></p>	<p style="text-align: center;"><i>Yes</i></p> <p style="text-align: center;"><i>3/24/21</i></p>
<div style="text-align: center;">             ENGINEERING              TECHNOLOGY              STATE OF HAWAII           </div> <div style="text-align: right;"> <b>APR 30 12:47 PM</b> </div>		

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-9 Personnel, staffing and family requirements. (b)(1) The substitute care giver who provides coverage for a period greater than four hours in addition to the requirements specified in subsection (e) shall:  Be currently certified in cardiopulmonary resuscitation;  <u>FINDINGS</u> SCG #1 - No cardiopulmonary resuscitation certification. Submit a copy with the POC.	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>Prior to initial nextest contact, PCG to ensure that SCG <sup>1st</sup> <del>was</del> is CPR certified, and obtain copy of certification for ANC# file.            PCG to use employee checklist, and to be check monthly, remind SCG one month prior to expiration.</p>	<p style="text-align: right;">3/24/21</p>

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RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-14 <u>Food sanitation.</u> (f) Toxic chemicals and cleaning agents, such as insecticides, fertilizers, bleaches and all other poisons, shall be properly labeled and securely stored apart from any food supplies.  <b>FINDINGS</b> A gallon bottle of bleach unsecured under a utility sink along the outside access to the area of refuge.	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u> <i>Yes.</i></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p style="text-align: center;"><i>Gallon bottle of bleach was put away in a secured/locked cabinet.</i></p>	<p style="text-align: center;"><i>9/12/20</i></p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-14 Food sanitation. (f) Toxic chemicals and cleaning agents, such as insecticides, fertilizers, bleaches and all other poisons, shall be properly labeled and securely stored apart from any food supplies.  <u>FINDINGS</u> A gallon bottle of bleach unsecured under a utility sink along the outside access to the area of refuge.	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>PCs to remind SCs to put away and lock all toxic chemicals. Signs are also to be made for toxic chemical cabinet. PCs <sup>they</sup> will check that all toxic chemicals are locked and secured in a cabinet. PCs will check daily.</p>	<p style="text-align: right;">3/24/21</p>

DENSIFICATION  
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 STATE OF HAWAII

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (b)            Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security. Medications that require storage in a refrigerator shall be properly labeled and kept in a separate locked container.</p> <p><b><u>FINDINGS</u></b>            "Diclofenac sodium 1% gel, Inzo barrier cream and moisture barrier antifungal cream" unsecured in unoccupied Bedroom #3.</p>	<p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b> <i>Yes.</i></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p><i>Medication was placed / stored properly in the medication cabinet.</i></p>	<p><i>9/11/20</i></p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-15 <u>Medications</u> . (b) Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security. Medications that require storage in a refrigerator shall be properly labeled and kept in a separate locked container.  <b>FINDINGS</b> "Diclofenac sodium 1% gel, Inzo barrier cream and moisture barrier antifungal cream" unsecured in unoccupied Bedroom #3.	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>Upon discharge of resident, PCs + SCs to make sure that room is clear of any medications.</i></p>	<p style="text-align: right;"><i>3/24/21</i></p>

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 STATE OF HAWAII  
 COMM-ONCA  
 STATE LICENSING

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-15 <u>Medications</u> , (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.  <u>FINDINGS</u> Resident #1 - "Simvastatin 20 mg 1 tablet by mouth every evening with evening meal" ordered 7/28/20; however, the September 2020 medication record noted the medication is taken at 8 a.m.	<p style="text-align: center;"><b>PART 1</b></p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u> Y/B.</p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>Simvastatin 20mg 1 tablet by mouth every evening with evening meal was properly recorded on MAR.</i></p>	<p style="text-align: center;">9/11/20</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-15 <u>Medications. (e)</u> All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.  <u>FINDINGS</u> Resident #1 - "Simvastatin 20 mg 1 tablet by mouth every evening with evening meal" ordered 7/28/20; however, the September 2020 medication record noted the medication is taken at 8 a.m.	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>PCG to ensure &amp; check <sup>medications</sup> existing MMR orders, all labels, MMR orders are all the same. PCG will make sure that SCG also double check medications MMR and labels.</p>	<p style="text-align: right;">3/24/21</p>

DIVISION OF LICENSING  
 COMMUNITY CARE  
 STATE OF HAWAII

APR 30 12:41 PM '21

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-15 <u>Medications</u> , (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.  <b>FINDINGS</b> Resident #1 - "Cipro 250 mg po BID x 5 days" ordered 8/24/20; however, the September 2020 medication record noted "Ciprofloxacin 200 mg tab take 2 tabs po 2x/day for 5 days." The medication was initiated as taken for 9/1/20 (am only), 9/2-10/20 8 am and 6 pm & 9/11/20 8 am (day of initial inspection). There was no physician order for "Ciprofloxacin 200 mg."  <div style="text-align: center;">             STATE LICENSING              BOARD              OF NURSING              STATE OF HAWAII           </div> <div style="text-align: right;">             12:17 PM APR 30 2021           </div>	<p style="text-align: center;"><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p style="text-align: center;"> <i>Unable to correct deficiencies @ this time.</i>   <i>Order clarified to physician.</i>   <i>Should have been strong.</i> </p>	<div style="text-align: right;"> <i>3/24/21</i> </div>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-15 <u>Medications</u> . (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.  <b>FINDINGS</b> Resident #1 - "Cipro 250 mg po BID x 5 days" ordered 8/24/20; however, the September 2020 medication record noted "Ciprofloxacin 200 mg tab take 2 tabs po 2x/day for 5 days." The medication was initiated as taken for 9/1/20 (am only), 9/2-10/20 8 am and 6 pm & 9/11/20 8 am (day of initial inspection). There was no physician order for "Ciprofloxacin 200 mg."  <div style="text-align: center;">             STATE LICENSING              BOARD              HAWAII              APR 30 12:31 PM           </div>	<div style="text-align: center;"> <b>PART 2</b>  <u>FUTURE PLAN</u> </div> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>after 1st time</i>  <i>Unable to correct deficiencies @ this time</i>  <i>PCG will ensure that when writing MAR, double check all medication labels and MD orders and MAR</i></p>	<div style="text-align: right;"> <i>3/24/21</i> </div>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-16 <u>Personal care services.</u> (h) A schedule of activities shall be developed and implemented by the primary care giver for each resident which includes personal services to be provided, activities and any special care needs identified. The plan of care shall be reviewed and updated as needed.  <u>FINDINGS</u> Resident #1 - No schedule of activities.	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u> <i>Yes</i></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p style="text-align: center;"><i>A schedule of activities was developed and implemented by the PCG for the resident that includes personal services to be provided, activities and any special care needs identified.</i></p>	<p style="text-align: center;"><i>9/11/22</i></p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-16 <u>Personal care services.</u> (h) A schedule of activities shall be developed and implemented by the primary care giver for each resident which includes personal services to be provided, activities and any special care needs identified. The plan of care shall be reviewed and updated as needed.  <u>FINDINGS</u> Resident #1 - No schedule of activities.	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>At the time of resident's admission, PCs to use admission checklist and use it as a tool to plan activities at resident's <del>pre</del> preferences.</p>	<p style="text-align: right;">3/24/21</p>

DEPARTMENT OF  
HUMAN SERVICES  
STATE OF HAWAII

APR 30 12:21 PM '12

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-17 <u>Records and reports.</u> (a)(1) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review:  Documentation of primary care giver's assessment of resident upon admission;  <u><b>FINDINGS</b></u> Resident #1 - No PCG assessment of resident upon admission. Resident admitted on 8/12/20.	<p style="text-align: center;"> <b><u>DID YOU CORRECT THE DEFICIENCY?</u></b> YES  <b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b>   <i>PC's assessment of resident upon admission was documented.</i> </p>	<p style="text-align: center;">9/11/20</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-17 <u>Records and reports.</u> (a)(1) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review:  Documentation of primary care giver's assessment of resident upon admission;  <u>FINDINGS</u> Resident #1 - No PCG assessment of resident upon admission. Resident admitted on 8/12/20.	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>Upon admission, PCGs to use admission checklist as a tool to make sure which documentations need to be done @ time of admission.</i></p>	<p style="text-align: center;"><i>3/24/21</i></p>

ILLINOIS STATE  
 BOARD OF  
 NURSING  
 APR 30 12.

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-17 Records and reports. (a)(4) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review:  A report of a recent medical examination and current diagnosis taken within the preceding twelve months and report of an examination for tuberculosis. The examination for tuberculosis shall follow current departmental policies;  <u>FINDINGS</u> Resident #1 - No medical examination and current diagnosis at the time of admission. <b>Submit a copy with the plan of correction (POC).</b>	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><u><b>DID YOU CORRECT THE DEFICIENCY?</b></u> <i>Yes</i></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p style="text-align: center;"><i>A copy of Resident's medical examination &amp; current diagnosis was obtained from patient's PCP.</i></p>	<p style="text-align: right;"><i>9/15/20</i></p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-17 Records and reports. (a)(4) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review:  A report of a recent medical examination and current diagnosis taken within the preceding twelve months and report of an examination for tuberculosis. The examination for tuberculosis shall follow current departmental policies;  <u>FINDINGS</u> Resident #1 - No medical examination and current diagnosis at the time of admission. <b>Submit a copy with the plan of correction (POC).</b>	<p style="text-align: center;">PART 2 <u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>Upon admission, PCT to use admission checklist as a tool to make sure which documentations needs to be done @ time of admission.</p> <p>Prior to admission, work to discharge planner to get admission document.</p> <p>When picking up resident, <del>make sure</del> <sup>after</sup> <del>make</del> <sup>check</sup> for admission documents and make sure that it was done.</p>	<p style="text-align: right;">3/24/21</p>

ENGINEERING  
DON-ORCA  
STATE OF HAWAII

13 LV APR 30 12.

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-17 <u>Records and reports.</u> (a)(7) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review:  Height and weight measurements taken;  <b><u>FINDINGS</u></b> Resident #1 - No admission height and weight taken and recorded.	<p style="text-align: center;"><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b> <i>Yes</i></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p style="text-align: center;"><i>Resident #1 - Height &amp; weight taken and records <del>will be</del> filed in a binder.</i></p>	<p style="text-align: center;"><i>9/11/20</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (a)(7)            The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review:             Height and weight measurements taken;   <u>FINDINGS</u>            Resident #1 - No admission height and weight taken and recorded.</p>	<p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><u>FUTURE PLAN</u></p> <p>PART 2</p> <p>Upon admission, PCs to <del>make</del> use admission checklist as a tool to make sure which documentations needs to be done @ time of admission.</p>	<p>3/24/12</p>

STATE LICENSING  
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 STATE OF HAWAII

157 APR 30 12.

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (a)(8)            The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review:             A current inventory of money and valuables.   <u>FINDINGS</u>            Resident #1 - No inventory of valuables. Resident admitted 8/12/20.</p>	<p style="text-align: center;"><b>PART 1</b></p> <p><u><b>DID YOU CORRECT THE DEFICIENCY?</b></u> YES</p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>PCG <del>with</del><sup>also</sup> performed an inventory on patient's valuables. Valuables are recorded and filed in patient's binder.</p>	<p style="text-align: right;">12/20/20</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-17 <u>Records and reports.</u> (a)(8) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review:  A current inventory of money and valuables.  <u>FINDINGS</u> Resident #1 - No inventory of valuables. Resident admitted 8/12/20.  <div style="text-align: center;">             LICENSING              BOARD              STATE OF HAWAII           </div> <div style="text-align: right;">             13:29 30 APR 12.           </div>	<div style="text-align: center;"> <b>PLAN OF CORRECTION</b>   <b>PART 2</b>   <u>FUTURE PLAN</u> </div> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>Upon admission, PCs to use admission checklist as a tool to make sure which documentations needs to be done @ time of admission.</i></p>	<div style="text-align: right;"> <i>3/24/21</i> </div>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-17 <u>Records and reports</u> , (b)(3) During residence, records shall include:  Progress notes that shall be written on a monthly basis, or more often as appropriate, shall include observations of the resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury, behavior patterns including the date, time, and any and all action taken. Documentation shall be completed immediately when any incident occurs;  <b>FINDINGS</b> Resident #1 - Admitted on 8/12/20 with a Foley catheter. Progress notes did not include the following changes in condition: <ul style="list-style-type: none"> <li>• 8/18/20 - Foley catheter removed. Encouraged increased fluid intake greater than 2000 ml/day.</li> <li>• 8/24/20 - Foley reinserted; started on Cipro 250 mg po BID x 5d.</li> <li>• 8/31/20 Foley removed.</li> <li>• No observations of resident's ability to void following Foley catheter removal.</li> <li>• No observations of resident's tolerance to Cipro.</li> <li>• No documentation if resident able to increase fluid intake to greater than 2000 ml/day.</li> </ul>	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><u><b>DID YOU CORRECT THE DEFICIENCY?</b></u> YES</p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p style="text-align: center;"><i>Documentation of observations findings was entered into resident's progress notes.</i></p>	<p style="text-align: center;">9/11/20</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-17 <u>Records and reports.</u> (b)(3) During residence, records shall include:  Progress notes that shall be written on a monthly basis, or more often as appropriate, shall include observations of the resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury, behavior patterns including the date, time, and any and all action taken. Documentation shall be completed immediately when any incident occurs;  <u>FINDINGS</u> Resident #1 - Admitted on 8/12/20 with a Foley catheter. Progress notes did not include the following changes in condition: <ul style="list-style-type: none"> <li>• 8/18/20 - Foley catheter removed. Encouraged increased fluid intake greater than 2000 ml/day.</li> <li>• 8/24/20 - Foley reinserted; started on Cipro 250 mg po BID x 5d.</li> <li>• 8/31/20 Foley removed.</li> <li>• No observations of resident's ability to void following Foley catheter removal.</li> <li>• No observations of resident's tolerance to Cipro.</li> <li>• No documentation if resident able to increase fluid intake to greater than 2000 ml/day.</li> </ul>	<div style="text-align: center;"> <b>PLAN OF CORRECTION</b>  <b>PART 2</b>  <u>FUTURE PLAN</u> </div> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>PCG to do proper documentation right away if there's any changes with patient's status, MD orders, or any observations.</i></p> <p><i>PCG to have progress notes easily accessible in order to do proper documentation right away.</i></p>	<div style="text-align: right;"> <i>3/20/21</i> </div>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§ 11-100.1-17 Records and reports, (h)(1) Miscellaneous records:</p> <p>A permanent general register shall be maintained to record all admissions and discharges of residents;</p> <p><b>FINDINGS</b></p> <p>Resident #1 - Admission was not recorded on the general register.</p>	<p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b> <i>Yes</i></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p><i>A register entry <sup>was</sup> <del>will be</del> filed in the binder.</i></p>	<p><i>9/11/20</i></p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> § 11-100.1-17 Records and reports. (h)(1) Miscellaneous records:  A permanent general register shall be maintained to record all admissions and discharges of residents;  <u>FINDINGS</u> Resident #1 - Admission was not recorded on the general register.	<p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>Upon admission, PCG to use admission checklist as a tool to make sure that proper documentation are done.</p>	<p style="text-align: right;">3/24/21</p>

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RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-19 <u>Resident accounts.</u> (a) The conditions under which the primary care giver agrees to be responsible for the resident's funds or property shall be explained to the resident and the resident's family, legal guardian, surrogate or representative and documented in the resident's file. All single transfers with a value in excess of one hundred dollars shall be supported by an agreement signed by the primary care giver and the resident and the resident's family, legal guardian, surrogate or representative.  <b><u>FINDINGS</u></b> Resident #1 - No financial agreement.	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u> YES.</b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p style="text-align: center;"> <i>PCG was able to obtain patient's signature of financial agreement. Document was filed in the resident binder.</i> </p>	<p style="text-align: right;"><i>12/28/20</i></p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<div data-bbox="1339 178 1372 220">☒</div> <div data-bbox="1339 262 1372 661">§11-100.1-19 Resident accounts. (a)</div> <div data-bbox="1063 262 1339 903"> <p>The conditions under which the primary care giver agrees to be responsible for the resident's funds or property shall be explained to the resident and the resident's family, legal guardian, surrogate or representative and documented in the resident's file. All single transfers with a value in excess of one hundred dollars shall be supported by an agreement signed by the primary care giver and the resident and the resident's family, legal guardian, surrogate or representative.</p> <p><b><u>FINDINGS</u></b> Resident #1 - No financial agreement.</p> </div> <div data-bbox="251 577 446 861"> <p>STATE LICENSING DOH-ORCA STATE OF HAWAII 13:29 APR 30 2012</p> </div>	<div data-bbox="1339 1249 1372 1365">PART 2</div> <div data-bbox="1258 1186 1299 1417"><u>FUTURE PLAN</u></div> <div data-bbox="1112 934 1226 1669"> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> </div> <div data-bbox="738 924 1071 1753"> <p>Upon admission, PCs to use admission checklist as a tool to make sure that proper documentation is done.</p> </div>	<div data-bbox="1193 1711 1274 1869">3/24/11</div>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-20 Resident health care standards. (a) The primary and substitute care giver shall provide health care within the realm of the primary or substitute care giver's capabilities for the resident as prescribed by a physician or APRN.</p> <p><b>FINDINGS</b> PCG and all SCGs - No training regarding Foley catheter care. Submit copies of training for each with the POC.</p>	<p style="text-align: center;"><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b> YES</p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p style="text-align: center;">Foley Catheter training was provided by Delia Villanueva, RN at President Charles Inc.</p>	<p style="text-align: center;">12/28/20</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> § 11-100.1-20 Resident health care standards. (a) The primary and substitute care giver shall provide health care within the realm of the primary or substitute care giver's capabilities for the resident as prescribed by a physician or APRN.  <b>FINDINGS</b> PCG and all SCGs - No training regarding Foley catheter care. Submit copies of training for each with the POC.	<p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><u><b>FUTURE PLAN</b></u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>PCG will be responsible to ensure that proper training/education is provided when there is new treatment ordered by the doctor.</p>	<p style="text-align: right;">12/28/24</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-23 <u>Physical environment.</u> (g)(3)(B) Fire prevention protection.  Type I ARCHs shall be in compliance with, but not limited to, the following provisions:  There shall be a clear and unobstructed access to a safe area of refuge;  <u>FINDINGS</u> Sliding lock on the half gate, identified at the time of the pre-licensing visit on April 1, 2020, was confirmed as removed on April 16, 2020. A slide locking device was found on the same gate.	<p style="text-align: center;"><b>PART 1</b></p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u> Yes</p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p style="text-align: center;"> <i>Locking device was uninstalled;              making clear and unobstructed access              to a safe area of refuge</i> </p>	<p style="text-align: center;">9/11/20</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (g)(3)(B) Fire prevention protection.</p> <p>Type I ARCHs shall be in compliance with, but not limited to, the following provisions:</p> <p>There shall be a clear and unobstructed access to a safe area of refuge;</p> <p><b>FINDINGS</b></p> <p>Sliding lock on the half gate, identified at the time of the pre-licensing visit on April 1, 2020, was confirmed as removed on April 16, 2020. A slide locking device was found on the same gate.</p>	<p><b>PART 2</b></p> <p><b><u>FUTURE PLAN</u></b></p> <p><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p><i>PCG will be responsible to make sure that all exits are free from any locking devices that can will create any obstruction.</i></p>	<p><i>12/28/20</i></p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-23 <u>Physical environment.</u> (g)(3)(B) Fire prevention protection.  Type I ARCHs shall be in compliance with, but not limited to, the following provisions:  There shall be a clear and unobstructed access to a safe area of refuge;  <u>FINDINGS</u> Sliding lock on the half gate, identified at the time of the pre-licensing visit on April 1, 2020, was confirmed as removed on April 16, 2020. A slide locking device was found on the same gate.	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>PCs to do a monthly perimeter of the house check to ensure that all are areas are clear &amp; unobstructed to access to safe area.</i></p>	<p style="text-align: right;"><i>3/24/21</i></p>

DIVISION OF LICENSING  
ARCHITECTURAL BOARD  
STATE OF HAWAII

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (g)(3)(D) Fire prevention protection.</p> <p>Type I ARCHs shall be in compliance with, but not limited to, the following provisions:</p> <p>A drill shall be held to provide training for residents and personnel at various times of the day or night at least four times a year and at least three months from the previous drill, and the record shall contain the date, hour, personnel participating and description of drill, and the time taken to safely evacuate residents from the building. A copy of the fire drill procedure and results shall be submitted to the fire inspector or department upon request;</p> <p><b><u>FINDINGS</u></b></p> <p>No fire drills conducted. Resident #1 admitted 8/12/20.</p>	<p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b> Y<sup>13</sup></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p><i>Fire drill was conducted with Resident #1.</i></p>	<p><i>9/11/20</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (g)(3)(D) Fire prevention protection.</p> <p>Type I ARCHs shall be in compliance with, but not limited to, the following provisions:</p> <p>A drill shall be held to provide training for residents and personnel at various times of the day or night at least four times a year and at least three months from the previous drill, and the record shall contain the date, hour, personnel participating and description of drill, and the time taken to safely evacuate residents from the building. A copy of the fire drill procedure and results shall be submitted to the fire inspector or department upon request;</p> <p><b>FINDINGS</b></p> <p>No fire drills conducted. Resident #1 admitted 8/12/20.</p>	<p>PLAN OF CORRECTION</p> <p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>It's to ensure that monthly fire drills are conducted and documented at a timely manner.</p> <p>We <sup>will use</sup> a checklist to <sup>also</sup> do monthly checks that includes fire drills.</p>	<p>3/24/21</p>

STATE OF ALABAMA  
HONORABLE JUDGE  
STATE OF ALABAMA

13:27 03 APR 12.

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (1b)(3) The Type I ARCH shall maintain the entire facility and equipment in a safe and comfortable manner to minimize hazards to residents and care givers.</p> <p>All Type I ARCHs shall comply with applicable state laws and rules relating to sanitation, health, infection control and environmental safety;</p> <p><b><u>FINDINGS</u></b> No single use hand drying towels at three (3) sinks (bathroom, kitchen, and sink in the resident living area adjacent to the bathroom).</p>	<p><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b> Yes</p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p><i>A single use hand drying towels at 3 sinks were placed.</i></p>	<p><i>9/11/20</i></p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-23 Physical environment (h)(3) The Type I ARCH shall maintain the entire facility and equipment in a safe and comfortable manner to minimize hazards to residents and care givers.  All Type I ARCHs shall comply with applicable state laws and rules relating to sanitation, health, infection control and environmental safety;  <u>FINDINGS</u> No single use hand drying towels at three (3) sinks (bathroom, kitchen, and sink in the resident living area adjacent to the bathroom).	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>PCG to ensure that ARCH has enough supplies. Remind SCG to refill any needed supplies. PCG to check that ARCH has paper towels, daily.</p>	<p style="text-align: right;">3/24/21</p>

DIVERSITY  
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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§ 11-100.1-23 Physical environment. (h)(4) The Type 1 ARCH shall maintain the entire facility and equipment in a safe and comfortable manner to minimize hazards to residents and care givers.</p> <p>Water supply. Hot and cold water shall be readily available to residents for personal washing purposes. Temperature of hot water at plumbing fixtures used by residents shall be regulated and maintained within the range of 100° - 120°F.</p> <p><b><u>FINDINGS</u></b> Hot water was 130° F.</p>	<p><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b> Yes.</p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p><i>PCs adjusted the hot water temperature to not exceed 120° F.</i></p>	<p><i>12/22/20</i></p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-23 <u>Physical environment.</u> (h)(4) The Type I ARCH shall maintain the entire facility and equipment in a safe and comfortable manner to minimize hazards to residents and care givers.  Water supply. Hot and cold water shall be readily available to residents for personal washing purposes. Temperature of hot water at plumbing fixtures used by residents shall be regulated and maintained within the range of 100°-120°F.  <u>FINDINGS</u> Hot water was 130° F.          13.24 APR 30 12.	<p style="text-align: center;">PART 2 <u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>Plan to do a monthly check for hot water using a thermometer</i></p>	<p style="text-align: right;"><i>3/24/21</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (o)(3)(B) Bedrooms:</p> <p>Bedroom furnishings:</p> <p>Each bed shall be supplied with a comfortable mattress cover, a pillow, pliable plastic pillow protector, pillow case, and an upper and lower sheet. A sheet blanket may be substituted for the top sheet when requested by the resident;</p> <p><b><u>FINDINGS</u></b> All pillows - no pliable plastic pillow protectors.</p>	<p style="text-align: center;"><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b> <i>YES</i></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p style="text-align: center;"><i>Resident's initials to be written in all pillows.</i></p>	<p style="text-align: center;"><i>9/11/20</i></p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-23 <u>Physical environment.</u> (o)(3)(B) Bedrooms:  Bedroom furnishings:  Each bed shall be supplied with a comfortable mattress cover, a pillow, pliable plastic pillow protector, pillow case, and an upper and lower sheet. A sheet blanket may be substituted for the top sheet when requested by the resident;  <u><b>FINDINGS</b></u> All pillows - no pliable plastic pillow protectors.	<p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><u><b>FUTURE PLAN</b></u></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p style="text-align: center;"> <i>Resident's pillows to be discarded after resident moves out of ACH or pass.</i> </p>	<p style="text-align: right;">9/11/20</p>

Licensee's/Administrator's Signature:

*Abigail Chapman*

Print Name:

*Abigail Chapman*

Date:

*10/8/2020*

Licensee's/Administrator's Signature:

*Abigail Chapman*

Print Name:

*Abigail Chapman*

Date:

*11/21*

Licensee's/Administrator's Signature:

*Abigail Chapman*

Print Name:

*Abigail Chapman*

Date:

*10/7/21*